**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

SOUTH TEXAS RADIOLOGY IMAGING CENTERS
P O BOX 29490
SAN ANTONIO TX 78229-0490

**Respondent Name**
TRAVELERS INDEMNITY CO

**Carrier's Austin Representative Box**
#05

**MFDR Tracking Number**
M4-12-1781-01

**MFDR Date Received**
JANUARY 25, 2012

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "We billed Travelers within 95 days. It was not until the claim denied for out of network provider and we submitted a request for reconsideration that received a past filing deadline denial. Per TDI-DWC Rule §133.20 we had 95 days from the time we were notified of Workers Compensation Insurance to file this claim."

**Amount in Dispute:** $97.61

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The Provider's Request for Medical Fee Dispute Resolution involves reimbursement for diagnostic services. The Provider submitted billing for X-rays. The Carrier reviewed the bill and denied reimbursement as this is a HCN-enrolled claim but the Provider is not a HCN provider. After requesting reconsideration, the Provider filed this Request for Medical Fee Dispute Resolution. The Provider contends they are entitled to reimbursement as a referral from the treating doctor. The Claimant's employer enrolled in the HCN prior to the claimant's date of injury, and the claimant's injury is covered by the HCN. The provider is not a contracted provider with Travelers' HCN. Neither the Provider nor the claimant contacted the Carrier to obtain authorization to treat outside the HCN. Consequently, the non-HCN Provider is not entitled to reimbursement from the Carrier for treatment of a HCN claim. The Carrier contends the Provider is not entitled to additional reimbursement."

**Response Submitted by:** Travelers, 1501 S. Mopac Expressway, Suite A-320, Austin, TX 78746

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| April 18, 2011 | Radiology | $97.61 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

## Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Tex. Admin. Code §134.600 sets out the fee guidelines for the reimbursement of workers' compensation non-emergency health care requiring preauthorization provided on or after May 2, 2006.
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated May 27, 2011
   - MCO3 – W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. SUBJECT TO MULTIPLE PROCEDURE DISCOUNTS AND IS PAID AT 100 PERCENT OF THE FEE SCHEDULE AMOUNT PER THE TEXAS PHYSICIAN FEE SCHEDULE, MEDICARE GUIDELINES.
   - HCND – 45 – CHARGE EXCEEDS FEE SCH/MAX ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT. YOU ARE NOT AN AUTHORIZED TRAVELERS HCN PROVIDER. AT THIS TIME YOUR SERVICES ARE BEING DENIED BY THE CLAIM ADJUSTER.

   Explanation of benefits dated September 22, 2011
   - TXH3 – 29 – THE TIME LIMIT FOR FILING HAS EXPIRED. PER TEXAS LABOR CODE 480.027, BILLS MUST BE SENT TO THE CARRIER ON A TIMELY BASIS, WITHIN 95 DAYS FROM DATES OF SERVICE.
   - HCND – 45 – CHARGE EXCEEDS FEE SCH/MAX ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT. YOU ARE NOT AN AUTHORIZED TRAVELERS HCN PROVIDER. AT THIS TIME YOUR SERVICES ARE BEING DENIED BY THE CLAIM ADJUSTER.

   Explanation of benefits dated October 18, 2011
   - W4 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION.

## Issues

1. Is the requestor eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §§133.305 and 133.307?
2. Is the requestor entitled to reimbursement?

## Findings

1. §133.305 (a)(4) defines a medical fee dispute as "A dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for the treatment of that employee's compensable injury." Non-network health care is defined in Section (a) (5) of the same rule as "Health care not [emphasis added] delivered, or arranged by a certified workers" compensation health care network as defined in Insurance Code Chapter 1305 and related rules…" 28 Tex. Admin. Code §133.307 (a) (1) similarly states that "This section applies to a request for medical fee dispute resolution for non-network or certain authorized out-of-network health care…" Documentation found supports that the services in dispute were provided to an injured employee enrolled in the Travelers HCN (health care certified network), and that the requestor is not a contracted by the Travelers' HCN to provide services to injured employees enrolled in that HCN. Although the requestor obtained pre-authorization (determination of medical necessity) to provide the services in dispute, it failed to obtain authorization from the Travelers' HCN to treat the injured employee outside the HCN as required by at Insurance Code Chapter 1305, section 1305.006 titled Insurance Carrier Liability for Out-of-Network Health Care. The division concludes that the services in this dispute may not be reviewed because the requestor failed to support that the services are authorized out-of-network care pursuant to 28 Tex. Admin. Code §133.307 (a) (1).

2. This dispute may not be resolved pursuant to 28 Tex. Admin. Code §133.307; for that reason, no additional reimbursement can be recommended.

## Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

**Authorized Signature**

| | | |
|---|---|---|
| | | March 4, 2013 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.